STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121983-001-SF**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this ____ day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On June 21, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on June 28, 2011.

The Petitioner is enrolled for health care coverage through the State of Michigan, a self-funded local government group. The plan, administered by Respondent Blue Cross Blue Shield of Michigan (BCBSM), is self-funded. Act 495 authorizes the Commissioner to conduct external reviews for state and local government employees who receive health care benefits in a self-funded plan. Under Act 495, the reviews are conducted in the same manner as reviews conducted under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on July 8, 2011.

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in the State Health Plan PPO *Your Benefit Guide*.

On February 23, 2011, the Petitioner, who has diabetes, obtained special shoes and inserts that were prescribed by Dr. XXXXX, D.P.M., in XXXXX. Dr. XXXXX is a member of XXXXX, a provider group that does not participate with BCBSM. The shoes and inserts were covered by BCBSM as durable medical equipment. The provider charged $395.00. BCBSM approved $122.88 and, after applying a 20% coinsurance, paid $98.30 leaving the Petitioner responsible for paying the balance of $296.70.

The Petitioner appealed the amount BCBSM paid. A managerial-level conference was held, and BCBSM issued a final adverse determination on June 10, 2011, affirming its claims decision.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's diabetic shoes and inserts?

IV. ANALYSIS

Arguments of the Parties

In its final adverse determination, BCBSM wrote:

> . . . Based on our review, your benefit package, and a phone conversation with you on 6/10/11 it has been determined the claim payment amount is correct. No additional payment amount will be made.
>
> When you use a network provider for covered services, you'll have no out-of-pocket costs. However, if you use an out-of-network provider, you will be responsible for out-of-pocket costs equal to 20 percent of the approved amount, and possibly the difference between the provider's charge and the approved amount. You did not utilize a network provider for the services listed above.

BCBSM indicated to the Petitioner that since the shoes and inserts were not ordered through a network provider he was responsible for the balance of $296.70.

The Petitioner indicates that his podiatrist's office called BCBSM regarding the Petitioner's eligibility for diabetic shoes and inserts. They indicate that they were told by BCBSM that the Petitioner was eligible for one pair of shoes and three sets of inserts each year. No mention was made of being a part of the "SUPPORT Program" network of providers. It was

not until after the shoes were fitted and ordered that the office received a fax with information about the SUPPORT Program.

BCBSM indicates that the SUPPORT Program is clearly and prominently mentioned in the benefit guide that governs the provisions of the Petitioner's contract. In addition, the applicable benefit guide is located on the State of Michigan's website, under the Michigan Civil Service Commission page.

Commissioner's Review

The *Benefit Guide* (page 10) provides the following:

> **Choosing a network provider**
>
> **Nonparticipating provider**
>
> Nonparticipating providers are providers who are not in the PPO network and do not participate in any BCBSM plan. If you receive services from a nonparticipating provider, in addition to the out-of-network deductible and copayments, you may also be responsible for any charges above BCBSM's approved amount. That is because providers who do not participate with BCBSM may choose not to accept our approved amount as payment in full for covered services. You may be required to file your own claim.
>
> When you use nonparticipating providers, we will send you our approved amount less the out-of-network deductible and copayments. You are responsible for paying the provider.

Based on this provision of the benefit guide, BCBSM paid the proper amount for the Petitioner's shoes and inserts given that a non-network provider was used.

The Petitioner argues that he was misled to believe his care would be paid in full. BCBSM does not believe misleading information was provided. Under PRIRA, the Commissioner's role is limited to determining whether BCBSM has properly administered health care benefits under applicable statutes and the terms of health plan's policy or certificate of coverage. Resolution of the factual dispute described by the Petitioner (what was said or not said during a telephone conversation) cannot be the basis of this decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds BCBSM correctly applied the provisions of Petitioner's benefit guide.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of June 10, 2011, is upheld. BCBSM is not required to pay any additional amount for the Petitioner's shoes and inserts.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, P.O. Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner